Electronic Transactions

General

Q. What health care transactions are required to use the standards under HIPAA?

A. As required by HIPAA, the Secretary of Health and Human Services is adopting standards for the following administrative and financial health care transactions:

- 837 — Health claims and equivalent encounter information.
- 834 — Enrollment and disenrollment in a health plan.
- 270/271 — Eligibility for a health plan.
- 835 — Health care payment and remittance advice.
- 820 — Health plan premium payments.
- 276/277 — Health claim status.
- 278 — Referral certification and authorization.
- COB — Coordination of benefits.

Q. I hear people talking about the 835 transaction or the 270/271 pair of transactions. What does that mean?

A. Transactions covered under HIPAA are often referred to by their transaction set and version. Instead of saying "ASC X12N 837 004010A1 X098", most people refer to that transaction as "837 Institutional (/Professional/Dental)."

A listing of the transactions/transaction pairs follows. For simplicity, transactions are identified only by their transaction set:

- 837 Health Care Claim:

— Dental
— Professional
— Institutional

- 270/271 – Health Care Eligibility Benefit Inquiry and Response
- 278 – Health Care Services Review; Request for Review and Response
- 276/277 – Health Care Claim Status Request and Response
- 834 – Benefit Enrollment and Maintenance
- 835 – Health Care Claim Payment/Advice
- 820 – Payroll Deducted and Other Group Premium Payment for Insurance Products

Q. How do I decode the transaction standards?

A. Transaction standards can be broken down into five parts. Example: ASC X12N 837 004010 A1 X098

- ASC – Source of a standard; in this case, the standard comes from the American National Standards Institute (ANSI) Accredited Standards Committee (ASC). This is occasionally shown as "ANSI ASC" or just "ASC". Both indicate the same source of a standard.
- X12N – A subcommittee of the ANSI ASC X12 committee; the X12N subcommittee defines EDI standards used in the insurance industry.
- 837 – A transaction set; in the case of the 837 transaction, Institutional, Professional, and Dental variations exist.
- 004010 A1– Version of the X12 standard; this is usually referred to as "version 4010". It identifies version 4 of the standard, Release 1, sub release 0. A1 refers to

the Addenda Version of the 4010 format, which is an amended version of the standard adopted on February 20, 2003.

- X098 – Internal reference numbers; in the case of the 837 transaction, three versions exist, Institutional, Dental and Professional. Reference numbers X096, X097, and X098 identify these, respectively.

Q. Is sending data on a disc considered an electronic transaction?

A. Yes

Q. When are web-based transactions considered to be part of Direct Data Entry systems, which are subject only to the data content portions of the standards, and when are they considered regular transactions which must meet both data content and format requirements of the standards?

A. If the sender is using his or her browser to directly enter information onto a server that is part of the receiver's system, then it is considered a direct data entry transaction. These need only meet the data content and data condition requirements of HIPAA rules. If, however, the data is entered onto a server, which is then repackaged in order to send to the receiver's system, the data is considered a transaction. These must be sent to the receiver in a HIPAA compliant transaction format.

Q. I would believe that any fields that cannot be collected from a HCFA 1500, should be sorted out from the 837 HIPAA IG and reviewed. How can my providers submit data they don't have? So either these fields have to be reviewed, and a new form has to be created, or HIPAA is going to have to change the dataset minimum required. Can someone shed some light on this?

A. HIPAA was not intended to cover paper transactions. It was intended for electronic transactions and all necessary data elements to be included in one file for complete processing. It is not enough for providers to upgrade to a software version that is "HIPAA compliant" or to use a clearinghouse that is compliant. Unless the provider in question implements remediation steps that include capturing the necessary data, that provider will still not be compliant even if they are using the latest software or clearinghouse. HIPAA EDI is not just about EDI format but also about the data content in those EDI transactions. The paper 1500 or UB92 claims do not have everything that the EDI transactions need.

Q. What are the different adjudication requirements? Doesn't HIPAA mandate all electronic claims be standard?

A. HIPAA requires that all electronic claims be submitted in a standard format and comply with all required data elements and those situational data elements that are applicable based on the conditions described in the HIPAA Implementation Guide. HIPAA does not impact payers' coverage rules. The Medicare free billing software is being developed to support the submission of Medicare HIPAA compliant claims only. The software will not capture any of the situational data elements that may apply to other payers, but not to Medicare. For example, the Professional HIPAA 837

Implementation Guide has fields for the service authorization exception code and immunization batch number.

Q. I am requesting clarification of Hospital Bulletin 03-10. In the second paragraph, reference is made to October 1, 2003, being the effective date for submitting claims in ANSI X12N 837 format, with the option being a UB92 paper claim. Is October 1st the effective date for the ANSI 837 format, or is it October 16, 2003, as federally mandated?

A. The October 1, 2003, implementation date required by MDCH is in reference to standard code sets, while the October 16, 2003, implementation date is in reference to the ANSI X12N format.

Q. Can you please let me know if Michigan Medicaid has deployed any contingency plans in the event a provider is unable to submit HIPAA claims as of October 16, 2003?

A. MDCH recently released the October 2003 Numbered Letter (L 03-26) detailing Michigan Medicaid's contingency plan for HIPAA Implementation. Please refer to this document on the MDCH website at: www.michigan.gov/mdch -> Providers -> HIPAA -> HIPAA Implementation Materials -> Numbered Letters.

837 Claims

Q. In the Medicaid claims processing system, is the patient always the same as the subscriber?

A. Yes. From the 837 Professional Companion Guide: "MDCH business rules require that the patient is always the subscriber. Therefore, MDCH does not expect providers to submit any Loop 2000C (Patient Heirarchical Levels) in a transaction set. Transaction sets that contain Loop 2000C information will be rejected."

Q. What is the difference in format of an 837 encounter vs. an 837 claim?

A. Nothing except encounters are coded RP (for reporting) and claims are coded CH (for charge). The Companion Guides will identify specific data needed for each format.

Q. Do PIHPs have to accept 837 from providers and affiliates?

A. The following are the Michigan Department of Community Health (MDCH) guidelines for 837 transactions:

- All MDCH contracted entities must be able to accept and process health care claims in the ASC X12 837, version 4010A1 format by October 2002.
- Electronic transactions sent to Prepaid Health Plans (PIHPs) or Coordinating Agency (CAs) from providers must be in a HIPAA compliant format.
- Encounter Data claims and Children's Waiver Claims sent to MDCH from PIHPs or CAs must be HIPAA compliant.
- Affiliate Community Mental Health Service Providers (CMHSPs) or CAs who send electronic transactions to PIHPs must be in a HIPAA compliant format.

Q. What type of response(s) would we receive when we send a claim file? What will contain information on the status (accepted/denied/reason)?

A. When a claim file is sent in *production*, there are three possible responses that could be generated:
1.) 997 Functional Acknowledgement (FA): Acts in acknowledgement of a received transaction.
2.) 835 Remittance Advice: Reports paid and denied claim status only, sum must balance to the sum of the warrant (Check).
3.) 277U (Unsolicited): This comes as a separate transaction from the 835. The U277 is automatically generated by the payer to report the status of claims that have pended for an extended period of time.

Q. What is the interpretation of the Implementation Guide for Loop 2010AA, Segment NM1, Element 67, Page 86, with reference to Provider ID and Tax ID? Do we send the Medicare Provider # or the Federal Tax Id #?

A. According to the MDCH 837 Companion Guides for both Professional and Institutional claims, the NM1 segment of the 2010AA Loop, element 67 requires that you use the ID number referenced in the prior element (66). If there is a 24 in element 66 it signifies an employers tax ID number will be in element 67, but if a 34 is in element 66 it signifies that a social security number is to follow. There is a third choice in the Implementation Guide, which is an XX, this would signify a Health Care Financing Administration National Provider Identifier is to follow. However, at this point there is no such number. Note that the Provider's unique 9-digit Medicaid ID should go in Loop 2010AA REF02 (preceded by a REF01 with "1D") as specified in the Companion Guides.

Q. Is it acceptable to put fractions of units of service delivered on the 837?

A. Units of service may not be reported to MDCH using decimal points or fractions.

Q. In reviewing the Companion Guide for the 837 Institutional claim, we were unable to find any clarification on the sender or receiver Id's. Could you please let us know what values are to be placed in these elements. We currently send claims for both Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Inpatient facilities.

A. These data elements are ISA and GS segments also called the EDI envelope. If you are the submitter of a file, then you would use the number assigned by MDCH at the time you became an authorized electronic biller as your submitter ID. The receiver ID would then be the number assigned to whom you are sending the file or the "receiver" of the file, which in the case of MI Medicaid would be D00111. This is documented in the Electronic Submitters Manual, which is posted on the MDCH website www.michigan.gov/mdch -> Providers -> Information for Medicaid Providers -> Michigan Medicaid Uniform Billing Project -> Electronic Claims Submission Information and refer to appendix B, page 9.

Q. What is the difference between the CAS and SVD segments in the 2430 Loop of the 837 claim? E.g., I have a claim that was originally $100. The primary payer

has paid $40, leaving the remaining $60 amount to be paid by the secondary payer or the patient. How do I map that in the 837 Professional claim? (Relative to the CAS & SVD segments)

A. As the HIPAA-mandated Implementation Guide for the 837 Professional claim states (page 555), data element SVD02 is the "amount paid for this service line." In your example, (assuming the claim has only one service line) this would be the $40 paid by the primary payer.
As noted on pages 558-565, the Loop 2430 CAS segment is used to identify the "service line-level adjustments that caused the amount paid to differ from the amount originally charged." Depending on how the primary payer adjudicated the service line, there may be several amounts. Altogether, these will add to the $60 that the primary payer did not pay. (This is called service line balancing.) Each amount will have an associated "Claim Adjustment Reason code." These include situations such as "deductible", "co-pay", "reduction to contract amount" etc. So, in the service line example you give, the $100 charge would go into data element SV102 (in the 2400 loop) and the amount paid on that service line ($40) would go into Loop 2430 SVD02 along with all the CAS segments that describe the $60 not paid on that service line would be provided so that the service line would "balance" (see the 835 Implementation Guide description of service line balancing on page 19). In general, you will be able to take the adjustment reason codes and corresponding amounts directly from the 835 or remittance advice you receive from the primary payer.

Q. We are a payer and our claims are received electronically from an agent who receives the claims from the providers, reprises them and sends the claims to us. My question is, since they are filing as a covered entity, would we still need to worry about the 837 since it would be like sending a claim to ourselves?

A. The payer can get the claim information from their business associate in any form they want. The repricer or BA in this situation is acting like a clearinghouse in transforming the document.

Q. Currently, we submit our Medicaid facility claims through the BCBSM/EPIC system, which routes these to the Medicaid payer. Will BCBSM modify the current claim format to support the X12N 837 format required by Medicaid?

A. Yes. Providers must use the BCBSM format and guidelines for this submission. Please visit the Blue Cross Blue Shield of Michigan (BCBSM) website for detailed information. Their website address is: www.bcbsm.com/providers/hipaacentral.shtml.

Q. If clearinghouses continue to accept NSF formats after October 16, 2003, will this be for all types of providers?

A. The NSF enhanced format can crosswalk data to 837 v 4010A1. However, this will not meet the requirements for ambulance, chiropractic, etc. For certification purposes, not all providers will be certified using NSF format, Claredi alone will certify NSF formats.

Q. If a provider is one of our covered entities and they send us electronic claims (837), then can we mandate they continue to do so? Will they receive electronic remittance advice (835)?

A. Under the provisions of the HIPAA Electronic Transactions regulation, if a provider or other applicable entity requests a health plan to conduct a transaction as a HIPAA compliant standard transaction, a health plan must do so and send the 835 RA in the electronic version.
On the other hand, if a health plan wishes to require a provider or other entity to use standard paper transactions for doing business with the health plan, nothing in the HIPAA Electronic Transactions regulation inhibits such an arrangement.

Q. According to the 837I Implementation Guide, the reporting of the Attending Physician's EIN or SSN in the 2310A Loop (Segment NM1, Element NM109) is required, and therefore an X12 compliance error will result if this data element is omitted. This presents a problem given that the EIN/SSN is not available for most of our attending physicians. I have contacted both BCBSM and UGS/Medicare regarding this issue, and both payers will accept a default value of "999999999" for the EIN/TaxID field. Will MDCH also accept a default value of "999999999" for the EIN/Tax ID field in loop 2310A, NM109?

A. In order to have a HIPAA compliant claim, the EIN or SSN must be used in the NM109 element of the 2310A Loop on inpatient claims, until such time as the Health Care Financing Administration National Provider Identifier is implemented. As in the case with Medicare, all fields are not currently edited at Medicaid.

Q. Are you shutting down or modifying any of your current systems that will require changes to the way providers send claims?

A. MDCH is in production with the 4010A1 (Addenda) version of the 837D, 837P and 837I. At the same time, we're also supporting B2B testing of the 837 v 4010 A1 for the Dental, Professional, and Institutional claims with providers, service bureaus or clearinghouses.
Our providers will be able to connect to our dial-up Data Exchange Gateway (DEG) using the same phone number and connection method for the foreseeable future. We have also made an alternative approach available to our trading partners, via the Internet, using an https connection. For details on that option or any questions regarding our DEG, I'd suggest you contact AutomatedBilling@Michigan.gov
Current trading partners will need to change their approach for the 835 and 277, eliminating our current proprietary electronic remittance advice file.
To stay abreast of these changes, as well as our activities to support the addenda versions of these transactions, I'd suggest you continue to monitor our web site, and feel free to send any questions regarding automated billing/connectivity, etc. to AutomatedBilling@Michigan.gov or to Jim Kunz at KunzJ@Michigan.gov.

Q. Would there be situations in which 0 quantity would be acceptable for either Professional or Institutional claims? Should this element always be greater than 0 and if 0 is acceptable in what situations?

A. For all Institutional Claims, MDCH requires a quantity greater than or equal to zero reported on all service lines. For all Professional claims the quantity must be greater than 0.

Q. Based on your recent response regarding the use of "8888888" vs. "888888888" for Medicaid ID for non-enrolled physician, you have indicated that seven 8's should be reported on the hard-copy UB-92. However, nine 8's should be reported on the 837I. Our physician file will only accommodate one of these formats for the Medicaid provider ID. We would prefer it to be the "2+7" format, as described in the MDCH document. However, we must also accommodate the ability to send hardcopy Medicaid secondary claims as paper UB-92s. Based on a recent phone conversation, the UB-92's received as hard copy claims will have a programming change to accommodate stripping off the first 2-digits of an "888888888" (9-digit) value. Can you verify that this will be done, since we are limited to using a single format (either 7 or 9 digits), for the Medicaid ID in our physician file?

A. The Billing Provider ID must reference a valid, 9-digit Medicaid ID.

Q. In the MDCH Companion Guide for the 837 Institutional claim (revised Feb.14, 2003) it states the following on page 3 (for Loop 2300, Segment HI (Principle Procedure and Other Procedure information):
"Use "BR" (ICD-9-CM Principal Procedure); Use "BQ" (ICD-9-CM Principal Procedure)"
Since the new HIPAA guidelines allow the use of ICD-9 procedure codes for "inpatient" claims only, does Medicaid require the reporting of Principal Procedure (or Other Procedure) information on "outpatient" claims?
If so, then should the Companion Guide include the use of the appropriate HCPCS code qualifiers ("BP", and "BO"), when reporting Principle/Other procedure for Outpatient claims?

A. No. Medicaid does not require the reporting of principle procedure (ICD -9-CM Principle Procedure) for outpatient hospital claims.

Q. It is my understanding that taxonomy codes are not yet a HIPAA requirement, but are required for the state of Michigan, is this true?

A. The Implementation Guide for version 4010A1 states that the taxonomy codes are situational. Michigan Medicaid will follow the guidelines for 837 claims. Please refer to our Companion Guides for the 4010A1 for a complete list of elements that are required for claim completion.

837 Encounters

Q. Who is required to submit encounter data?

A. Health Plans will be responsible for submitting encounter data for Medicaid recipients based upon claims they receive from their contracted providers.

Q. We will be submitting encounter data using the 837 v4010A1 format beginning in October 2002 (due by the 15th of the following month), but what about the additional demographic data that is required but not on the 837 v4010A1?

A. Prepaid Inpatient Health Plans (PIHPs), Community Mental Health Service Programs (CMHSPs) and Coordinating Agencies (CAs) are required to submit the additional demographic data on a monthly basis using the Quality Improvement (QI) specifications provided in the Supplemental Instructions for 837 Encounter and Quality Improvement (QI) Data Submission for Prepaid Health Plans (PHPs) and Community Mental Health Service Programs (CMHSPs) and the Supplemental Instructions for 837 Encounter and Quality Improvement (QI) Data Submission for Substance Abuse Coordinating Agencies distributed in October 2002.

Q. When do we report encounters?

A. Report encounters within 30 days of full adjudication of the claim. At the end of the fiscal year, you will have ninety days to reconcile encounters that have not been adjudicated.

Q. For encounter reporting, do we report paid claims only or is it necessary to report denied claims?

A. Report every encounter regardless of payment source or nonpayment. Do not let billing rules limit encounter data reporting.

Q. Is there a time frame for submitting replacement encounters?

A. No.

Q. Some of our providers will be submitting paper claims to us, UB92 and/or HCFA 1500. All of the data that could be in an 837 is not on the paper form(s). When we process these claims and then prepare the outbound 837 encounter, is there any kind of a problem with this information gap. Our inclination is there should not be as HIPAA doesn't require migration from paper to electronic and it is not possible to expect someone who might provide a service like "family/friend" respite for a few hours a month to make the leap to submitting electronic HIPAA compliant 837s. The question is, will the State have a problem with information missing from an 837 when the cause is the form in which the claim came into us?

A. The issue is not what MDCH will allow but rather the requirements of the ASC X12N 837 format.

- Health Plans will have to make certain that required data elements as outlined in the National Electronic Data Interchange Transaction Set Implementation Guides are reported to ensure acceptance of the transaction. This may require health plans to supplement data submitted by the provider.
- Please refer to the Implementation Guide and the Companion Guide when preparing HIPAA compliant 837 claims. MDCH may not require some of the data submitted on a compliant 837 but if reported will not impact adjudication. Additionally, there are "situationally required" elements that MDCH may need in order to adjudicate the claim.

Q. In a situation where a PIHP contracts with another PIHP to provide a service for a consumer, which PIHP reports the 837 encounter?

A. The PIHP that pays for the service should report the 837 encounter.

Q. How much time do we have to correct submissions that are rejected?

A. Data submissions (encounter and QI) rejected by the system must be resubmitted within 30 days of the date the Error Return File was created.

Q. On the 837 P encounter, Loop 2300, CN1, CN101, the Companion Guide says to use "05" when the plan has a capitated arrangement with the billing provider. We do not have an arrangement to cap our providers, but we are unclear if the State expects us to put in the "05" because we are capitated with the State?

A. Loop 2300, CN1 (Contract Information) should be reported when the encounter is reporting only capitated services. The information within this segment refers to the contract arrangement between the health plan and the provider. If the health plan does not have a capitated arrangement with the provider, Loop 2300, CN1 would not be reported.

835 Claim Payment & Remittance Advice

Q. Can we mandate that a covered entity must send us 837 electronic claims? Will they receive electronic remittance advice (835)?

A. Under the provisions of the HIPAA Electronic Transactions regulation, if a provider or other applicable entity requests a health plan to conduct a transaction as a HIPAA compliant standard transaction, a health plan must do so and send the 835 RA in the electronic version.

Q. When sending the 835, does the original 837 HAVE to go out with the 835?

A. Not all the elements received on the 837 have to go out on the 835. However, the original procedure codes have to be returned on the 835.

Q. The 835 transaction contains both a claims adjustment reason code and a remittance remark code. Are we required to provide both? Where can we find the current reason and remark codes?

A. No. According to the Implementation Guide, the Adjustment Reason Code is required and the Remark Code is optional. Current lists of these codes are posted at www.wpc-edi.com/hipaa. The codes are typically updated in March, July, and November, following scheduled X12 meetings. CMS has the remark codes posted there to enable both code sets to be accessed at the same web address.

Q. What is the difference between the reason and remark codes that are used in remittance advice transactions?

A. Reason codes explain the basis for a denial, reduction or increase in payment for a service. Only reason codes may be reported in the claim adjustment segments of remittance advice transactions. Remark codes are reported in an MIA or MOA segment at the claim level, or in an LQ segment at the line level of an 835 remittance advice. Remark codes are usually used in conjunction with reason codes to explain appeal rights and to augment information expressed by a reason code. Remark codes cannot be used in and of themselves to deny or otherwise adjust a claim or service in a remittance notice.

Q. Why isn't all of the information in the 835 or NSF remittance advice reported in paper remittance advice notices?

A. Electronic remittance advice (ERA) transactions contain hundreds of data elements. It is not practical or cost effective for CMS to print out each of those data elements. We have included the most frequently used data elements in the paper notices, but providers who need supplemental data must begin to receive ERAs.

Q. In the 835 Implementation Guide, there is a reference to the Payer Identifier in Loop 1000A. N101 Entity Identifier Code is required, value = PR. Does this reference codes from External Source 540 or are additional values besides "XV" supposed to be listed? This Loop is causing test claims to fail and I am not sure of the resolution.

A. First, there are a couple of typos in N103 and N104, where it says "Required if the National Plan ID is ***not*** transmitted in N104." Obviously the word "not" should not be there, or it would conflict with X12 syntax (N103) or not make any sense (N104). So, that needs to be corrected. It has been corrected in the Addenda (A1) version. When the 835 IG was written, the National Plan ID was expected to be the "primary" payer identifier. We don't have it yet. So, here is how you use it until we have a National Plan ID: N101 = "PR"; N102 = payer name, like "BCBS of XX"; N103 = not used; N104 = not used. REF01 = "2U" REF02 = payer ID number, like "00303" or REF01 = "NF"; REF02 = NAIC co-code, like "60054" for Aetna. The code used with qualifier 2U does not need to be 5 digits. It could be just "303" if that is what the payer uses to identify itself. But it should be consistent. Given that there are multiple ways to identify a payer, there could be two payers that invent the same ID code for themselves. So, that is why the preferred use is to use the NAIC code. But not all payers have an NAIC code. Also, be aware that the way a payer identifies it in the 835 (both in the 1000A Loop as well as in the BPR10/TRN03) may be different from the way that a clearinghouse identifies a payer. So when you talk with a provider, they may not understand the payer ID you are using and they could know the payer by a different ID.

Q. Will MDCH provide a "sample" test 835 remittance file on their website, so that hospitals would be able to use it to validate their test system support for an 835?

A. Sample 835s are posted on the MDCH website for Provider Types 10, 30 and 40.

Q. Will our paper remittances be affected by your changes?

A. Yes, Please refer to "July 2003 All Provider HIPAA Letter", found at the MDCH website at: www.michigan.gov/mdch -> Providers -> HIPAA -> HIPAA Implementation Materials, then look for the link under "MDCH Numbered Letters".

Q. Because the hospital receives electronic remittance, will our payments for professional services now come on their electronic remittance?

A. This would be the case if all providers from the hospital are under the same Tax Identification Number (TIN).

Q. Will there be a software package made available by the State that we can use to print the 835 remittance advices?

A. At this time, the State will not be making a software package available to read the 835 transaction.

Q. Is the U277 sent on a regular basis by Medicaid (i.e. once per month) once the billing agent requests it, or must they request it each time?

A: The 277U is sent on the same time cycle as the 835 and paper RA. The 277U will be generated for everyone requesting an 835.

Q. What about pended claims for those providers who don't bill electronically?

A. Technically, if a provider doesn't bill electronically they can still get an 835/277U. They will need to select a service bureau to receive the transactions. They will also continue to get the paper RA.

Q. Will Medicaid send both paper & electronic claims on the 835?

A. Yes, both paper and electronic will be reported on the 835 and 277U.

Q. Will Medicaid provide a detailed breakdown with both the check and the voucher of the various components of the 835? Without this information, the new system will be chaotic for hospitals to manage. Can you provide any insight?

A. The State will begin remitting all payments associated with the same tax id in one payment device, either a voucher (paper check) or EFT. The State will continue to send a separate paper remittance advice to each provider. The electronic 835 remittance advice will be available and sent to the service bureau designated by the owner of the tax id. The 835 remittance advice transaction will detail out all paid and denied claims for provider associated with the tax id.

Q. If there are several entities operating under that identification number how do you determine which address the remittances will be sent to?

A. In cases where there are multiple providers associated with a TIN, the State will contact the organization that is associated with the TIN and determine the most appropriate method to process the (single) payment and the correct service bureau to use for the RAs. Some organizations are using their existing service bureaus to process their RAs & some are choosing to establish a service bureau just for receipt of RAs.

820 Capitation Payment Transaction

Q. We receive files monthly through the Data Exchange Gateway (DEG) that lists those individuals enrolled in Medicaid and covered by our agency. Will that continue?

A. For the time being, you will continue to receive your list of enrollees through the DEG. As progress toward HIPAA compliance continues, that will change. Enrollment information will be transmitted using the 820 and 834 formats. These will be ready for testing by April 1, 2003, leading to full implementation by October 16, 2003.

834 Enrollment / Disenrollment

Q. It is our understanding that we will continue to receive the 834 equivalents of the Card Cut-Off (3653), First of the Month (3653S) and Weekly (4684) enrollment files. How can each 834 be recognized as its proprietary file equivalent?

A. MDCH will post all EDI Transactions to the corresponding service bureau mailbox. 834 Card Cut-Off, First of the Month and Weekly files will be distinguished by their file name:

Card Cut-Off	ID: 4976(T/P)*
First of the Month	ID: 5012(T/P)*
Weekly	ID: 5013(T/P)*

**NOTE: File names will be followed by a "T" when testing or a "P" when in production.*

Q. Regarding QI data, what about information on consumers who receive services at different PIHPs within the same year?

A. The consumer will have a separate QI record for each PIHP where he/she receives services**.**

278 Referral Authorization

Q. Can the 278 transaction be used for authorizations for non-formulary drugs?

A. No. The pharmacy industry uses the transaction, NCPDP Version 5.1. This can handle the prior authorization in real time. If you do not have a pharmacy practice management system handy, then inquire with software companies that have applications for people with very limited needs for submitting drugs, getting authorizations, performing COB, etc.

270 Eligibility

Q. What is the HIPAA compliant process for sending and receiving eligibility data?

A. The HIPAA compliant process for sending eligibility information is known as the 270 transaction. The subsequent response to the 270 request is known as the 271 transaction. Information regarding either the 270/271 transaction can be found in the respective Implementation Guides & addenda published on the Washington

Publishing Company website: http://www.wpc-edi.com/hipaa/hipaa_40.asp